Emergency Involuntary Procedures (EIP) Work Group
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010

February 12, 2016 – 10:30am – 12:00pm

DRAFT Minutes

Attendance: Dr. Batra, Emma Harrigan and Karen Barber; DMH, Paul Capcara; CVMC, Linda Cramer; DRVT, Sarah Squirrell; VCPI, Jeff Rothenberg; VPCH, Jeffrey McKee; RRMC, Michael Sabourin; VPS

Phone: David Mitchell; VPCH, Jan Sherer; Springfield Hospital, Sheri Providence; Brattleboro Retreat

Introduction: Introductions took place around the table. One additional agenda item is a brief update on the administrative rule that was passed by Karen Barber. UVM MC is not able to attend the meeting today so they sent a written report.

Report to the Emergency Involuntary Procedures Review Committee (Statewide Data Review): Emma Harrigan reviewed the document with the members. She noted the following:

Page 3 – Aggregate EIP's for Involuntary Patients Adult Psych Units by type of procedure: There were 361 procedures, which is down from last quarter. There is a downward trend, decreased by 20-50%.

Page 4 – Aggregate EIP's for Involuntary Patients Youth Psych Units by type of procedure: There were 39 procedures. There were no more than 25 in any month. December was low with just 5 total procedures during the month.

Page 5 – Aggregate EIP's for Involuntary Patients Psych Units – Summarized in one chart, there is still the downward trend. There were 400 total procedures, down from 503 from last quarter.

Page 6 – Aggregate EIPS – type of procedure by unit: adult and youth together. This is consistent with what we have seen in previous quarters. Most units are all pretty similar. Brattleboro unit has less than 20 procedures by quarter.

The average number of closed beds each day is reported to the legislature and is on the website.

Page 7 – Aggregate Procedures per patient: There was a small sentence in notation that: For the purposes of this report, Level 1 Status is defined by unit reported in the EIP Certification of

Need (CON), not the patient's status determination. We made a revision this quarter and added the estimation of all adults that are currently in involuntary beds across the system. 79 or 61% did not have an EIP during the study period. Trends are consistent with what we have been seeing.

Question: What is the total number served? 130

Page 8 – Aggregate EIP's for Involuntary Patients: Episodes per patient. This is the same information broken out by episode. Again, the same trends we are seeing

Page 9 - EIP's on Level 1 Units. This is based on patient location not the determination. Brattleboro Retreat, Tyler 4 bounced around a bit.

Question – Paul – was wondering how it was differentiated between Involuntary patients and voluntary. It turns out CVMC is sending all of their CON's to Emma when they only need to send the ones for Involuntary Patients.

Question – Does the data for involuntary include people on a 72-hour hold? Yes, in a unit but not in the ED.

Questions – Who would we talk to, to address the ED? Each individual hospital should have the data.

Question – the last two pages of the report, if you added in a category of all the involuntary patient hours, what is that percentage? We don't have a reliable means for the denominator to calculate per 1000 patient hours which is why we don't have one.

Question – On the CON, could there be a box added to collect this information? It would be an extra resource issue and a discussion with the hospitals about reporting the overall rate of Involuntary data.

There is a disagreement for the way that information would get included in the report, what format is appropriate; this would not be a direct comparison.

Comment– The ED's would need to get involved. We would need to follow up with VAHHAS as this is outside the scope of this committee.

Comment – re: the hours of seclusion and restraints– Emma is going to add a chart to the report so that information will be available.

Comment – Start making the EIP's also a GoToMeeting so people can look at all information.

VCPI Update on Roll Out of Six Core Strategies (Sarah Squirrell) - Sara noted that they are continues to facilitate the performance improvement implementation. This work was started in

the summer of 2014, about 18 months ago. In an effort to continue to train new staff, given the high number of turnover that is experienced, they had implemented another 2-day training this past November, with over 90 attendees. Some of the attendees included folks from: NAMI, DRVT, WWC, VPS, Merry Meadow and WCMHS. There is a broad statewide interest also outside of just the hospitals.

At this 2-day event, DMH did a presentation on the data. It was also an opportunity to recognize the great work of the hospitals. RRMC was recognizes with an order of excellence.

They have funding to continue an ongoing learning community with Dr. Huckshorn. They are trying to ask the question: How do we help with implementation with all of the challenges and barriers that come up?

They are thinking about specific trainings areas around workforce development, where hospitals see common areas of interest. Is there a way we can do that more systematically together and create a common language, thinking collectively?

Where are we going from here? We have funding to continue the learning collaborative and consultation through the end of this fiscal year and are now moving towards an implementation threshold. If we can get more funding, we are thinking about sustainability and scope and how do we continue it; how do we anchor it?

Comments - Thank you Paul for deciding to go ahead and have CVMC be involved in this effort.

EIP Administrative Rule (Karen Barber) – The rule passed through LCAR in December. The rule goes into effect 90 days from the date it is filed with the Secretary of State's Office. DMH will file the rule on 4/1/16 for it begin on 7/1/16, giving hospitals the chance to make any necessary changes before it begins. DMH will be doing some trainings for hospitals on the rule to answer any questions they may have.

Comments - Will there be an opportunity outside of the hospitals to do the trainings? We hadn't discussed that but we can take that into consideration.

The webinar on designation rules was helpful as it was a step by step process on what the implementations were.

Hospital EIP Discussion

UVM Medical Center (report only)

- **Your structure for reviewing and overseeing EIPs on the unit as well as administrative level**.

UVMMC Inpatient Psychiatry leadership team review and audit all EIPs, 100% of the time. Specific educational efforts for all disciplines result from these in depth reviews.

There is a nursing leader and a physician available in house 24 hours/day year round. When an EIP occurs on the unit nursing leadership and a physician respond.

- **Leadership involvement and follow-up on EIPs and trends**

EIP data is reviewed weekly by Inpatient Psychiatry leadership including the Medical Director and the Nurse Manager. Representatives from the Jeffords Institute for Quality and the Security team also attend.

EIP data is reviewed quarterly by the unit Quality Council which consists of members from the multidisciplinary team, including Patient and Family Advisors.

Multidisciplinary team meetings for case review can be requested by any member of the team, and are scheduled on an individual basis. Specific educational efforts for all disciplines result from all levels of review.

- **What were the broad themes behind the data on your unit during the period being reported. E.g. if one or two patients had the most number of EIPs what were the challenges with those individuals and what interventions were successful with them.**

We had 3 outliers in the reporting period.

One of them was an elderly female patient who had fluctuating delirium clouding her concurrent acute psychiatric presentation. She lacked capacity, eventually was assigned a guardian. She had concurrent severe medical illnesses with high morbidity index that were contributing to her behavioral dis-inhibition and inability to engage with daily care. Some of the EIPs were performed to administer specific medical treatment that were necessary and authorized by the guardian via probate court order (restraints). Others were to avoid falls - alternatives were explored at length - even obtaining durable medical equipment (merry walker) used in long term facilities for ambulation.

Another patient was diagnosed with acute mania given her past history of bipolar disorder and self-taper off of lithium over the prior few months. During the initial part of her hospitalization pt presented with unpredictable episodes of extreme irritability, hostility, rapid speech and decreased sleep. The patient assaulted two staff members in separate instances and was frequently presenting a danger to other patients, while demonstrating intrusive behavior. She did not respond to attempts to redirect her behavior.

The third patient was initially admitted with severe psychotic disorganization. Shortly after admission she began exhibiting symptoms consistent with an emerging mania, including irritability, rapid speech, racing thoughts, poor sleep, and impulsivity, as well as worsening

psychotic symptoms including disorganized thoughts and behaviors as well as increased responses to internal stimuli. As her manic symptoms became more severe, she became intrusive with other patients and staff. A 2:1 observation was required in an effort to re-direct her out of other patients' rooms and personal space. She found benefit from using the seclusion room, with the door open, as a place of low stimulation. She was placed in a room at the end of hall, away from the main hall, to promote decreased stimuli. In general, pt's actions were in response to increased external stimuli, such as when other patients are loud or during shift change. Numerous emergency events occurred, and pt responded best to seclusion, over emergency medications. She required numerous redirections by manual restraint.

- **What performance improvement projects do you have ongoing or completed (more specific than six core strategies) to reduce EIPs in your hospital.**

We have engaged other departments in the academic medical center in the dialogue about reducing and avoiding use of EIP. The Administrative Nurse Coordinator team has worked on the revision for the debriefing process. Our 6 Core Strategies work group has presented at staff meetings around the hospital including the security team and Patient Support Services

The coping tool and coping plan created by the 6 Core Strategies work group is now in the electronic health record and can be accessed by anyone from the team.

The Inpatient Psychiatry nursing team trialed Bedside Nurse Introductions for 3 months. The Nurse Practice Council is working on ways to stream line this process.

The 6 Core Strategies Model is included in new staff orientation and annual mandatory trainings.

We have presence of consumers in all levels of administrative processes: operations meeting, quality meetings.

Comment - What did they learn? What is the next step? What did they do? What are the strengths, what worked, some specifics? It becomes tricky to keep data anonymous – that is why it is non-specific.

We are more interested in what did go well?

RRMC – Presentation is attached in email

We have tried to fully implement as best we can in all six areas of the Six Core Strategies. They are refining these and continue to meet monthly. They had a celebration meeting after their first year, with a presentation to the board. They celebrated their success and asked where do we go from here? Each committee is redefining its goals from the past year. Every committee exceeded expectations during the first year. They are looking for the committee to expand its scope beyond the Six Core Strategies to also include patient satisfaction. What we doing for the

patients to give them the best quality of care and certainly reduction of EIPs is the most important. The Leadership committee looks at every EIP. They get multiple lawyers of review.

They have implemented a weekly rotation schedule of on-call, 24/7, of their leaders when an EIP happens to review. Dr. McKee received two calls last week. The intent of these calls are to identify: were processes followed, were we paying attention to things when they happened, identify if there needs to be a formal debriefing; was there any injuries, was there something that didn't go right? Most of their EIPs are of the patient escorted back to their room type.

We expect to ask questions to the staff that are calling that I would like them to address in the end of each shift. Staff have found this supportive.

The first four slides data goes back to 10/14 and this is the data we presented to the key leaders of the medical unites, ED's and to leadership. We have real data to show. Restraints are clearly on a downward trend.

The next graph in the quarter shows that it went up a bit, most of this is in October and is related to two patients. One of the patients required constant attention, unpredictably would strike out at someone, hurt themselves. The other patient was volatile and was much more stable after a couple of days on the court ordered medications.

1-1 staff are getting verbally, physically threatened.

Question: Do you lessen the time of 1-1 staff in those situations? We coach the staff and have a tap out protocol where if they are frustrated and can't respond in a positive manner, they can say I need a break and someone else will come in.

Comment: ED's have expressed an interest in coming up a unified plan for people that are in the ED's often. How do other hospitals handle this person? This is something worth exploring.

Comment - Another idea could be that the staff travel with that person so that they have the continuation of care to each hospital.

Comment: There was an idea about outliers. You miss the fact that with every other admission we were hitting it out of the park. Is there a way to somehow remove them from the data or separate them from the data?